69-44. Long-Term Care Insurance.

Section 1. Definitions.

Unless the context otherwise requires, the following definitions shall apply as the terms are used in both this regulation and Act 466 of 1988 (The Long-Term Care Insurance Act of 1988).

A. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide benefits for not less than the period of time required by Act 466 of 1988 and any amendments thereto, for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization. Long-term care insurance does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

B. "Applicant" means:

- (1) in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and
- (2) in the case of a group long-term care insurance policy, the proposed certificate holder.
- C. "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.
- D. "Commissioner" means the Chief Insurance Commissioner of this State.
- E. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this State and issued to:
- (1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or
- (2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
- (a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and
- (b) Has been maintained in good faith for purposes other than obtaining insurance; or
- (3) An association or a trust or to the trustee of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering the policy within this State, the association or the insurer of the association shall file evidence with the Commissioner that the association has at the outset a minimum of one hundred persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one year, and has a constitution and bylaws which provide that the association holds regular meetings not less than annually to further the purposes of its members, except for credit unions, the association collects dues or solicits contributions from members, and the members have voting privileges and representation on the governing board and committees. Ninety days after the filing, the association is considered to have satisfied the organizational requirements unless the Commissioner makes a finding that the association does not satisfy those organizational requirements.
- (4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:
- (a) The issuance of the group policy is not contrary to the best interest of the public;
- (b) The issuance of the group policy would result in economies of acquisition or administration; and
- (c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization. Section 2. Policy Definitions.

No long-term care insurance policy delivered or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

- A. "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
- B. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
- C. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.
- D. All providers of services, including but not limited to "nursing homes," "community residential care facilities," and "home care providers" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.
- Section 3. Policy Practices and Provisions.
- A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 4 of this regulation.
- (1) No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable."
- (2) The term "guaranteed renewable" means that the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.
- (3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.
- B. Limitations and Exclusions. Exclusion or limitation of benefits on the basis of Alzheimer's Disease is not permitted. No policy may be delivered or issued for delivery in this State as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
- (1) Preexisting conditions or diseases.
- (2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease.
- (3) Alcoholism and drug addiction.
- (4) Illness, treatment or medical condition arising out of:
- (a) war or act of war (whether declared or undeclared);
- (b) participation in a felony, riot or insurrection;
- (c) service in the armed forces or units auxiliary thereto;
- (d) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or
- (e) aviation (this exclusion applies only to non-fare paying passengers).
- (5) Treatment provided in a federal government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle

no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

- (6) This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations or to prohibit the use of waivers or riders to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition, or extra hazardous activity. Where waivers are required as a condition of insurance, signed acceptance by the insured is required.
- C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.
- D. Continuation or Conversion.
- (1) Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.
- (2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.
- (3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.
- (4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the policy from which conversion is made restricts provision of benefits and services to named providers or facilities, and the circumstances of termination make continued use of these providers or facilities impossible or impractical, the converted policy shall provide coverage on an indemnity or expense incurred basis with benefits determined by the Commissioner to be substantially equivalent to the reasonable cost of services provided by the named providers or facilities, and shall not restrict provision of benefits and services to any named providers or facilities.
- (5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.
- (6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
- (7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:
- (a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due, or
- (b) The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:
- (i) providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

- (ii) the premium for which is calculated in a manner consistent with the requirements of subsection (6) of this section.
- (8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.
- (9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
- (10) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage. For the purposes of this section, "continuation of coverage" means the maintenance of coverage under the existing group policy as if no terminating event had occurred, and which is subject only to the timely payment of premium when due.
- (11) In cases of continuation of coverage, premium payments for coverage under the group policy may be made by the individual insured directly to the insurer, notwithstanding the provisions of Section 38-71-730(5).

E. Requirement for Home Care.

When an insured meets the requirements under the policy for a determination that care in a nursing home or community residential care facility is necessary, the insured shall have the option of receiving necessary care in the home or community, with daily benefits at the same level that would be paid for care in a nursing home or community residential care facility.

F. Option for Inflation Protection.

All insurers issuing long-term care insurance policies on an indemnity basis, must offer, as an optional benefit, an inflation protection adjustment which provides for automatic future increases in the level of benefits without evidence of insurability. Adjustments must be at a level which provides reasonable protection from future increases in the costs of care for which benefits are provided.

Section 4. Required Disclosure Provisions.

- A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.
- B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.
- C. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

- D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
- E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility shall set forth a description of such limitations or conditions, including any required number of days of confinement in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

Section 5. Requirements for Solicitation and Replacement.

All individual and direct response solicited long-term care insurance policies, regardless of issue age, shall be subject to compliance with the provisions of Regulations 69-34.1 and 69-34.2.

Section 6. Discretionary Powers of Commissioner.

The Commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

- A. The modification or suspension would be in the best interest of the insureds; and
- B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- C.(1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
- (2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
- (3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Section 7. Loss Ratio.

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

- A. Statistical credibility of incurred claims experience and earned premiums;
- B. The period for which rates are computed to provide coverage;
- C. Experienced and projected trends;
- D. Concentration of experience within early policy duration;
- E. Expected claim fluctuation;
- F. Experience refunds, adjustments or dividends;
- G. Renewability features;
- H. All appropriate expense factors;
- I. Interest:
- J. Experimental nature of the coverage;
- K. Policy reserves;
- L. Mix of business by risk classification; and
- M. Product features such as long elimination periods, high deductibles and high maximum limits.

Section 8. Filing Requirements.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this State pursuant to Section 5 of Act 466 of 1988 (The Long Term Care Insurance Act of 1988), it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this State.

Section 9. Standard Format Outline of Coverage.

This section of the regulation implements, interprets and makes specific the provisions of Section 6F of Act 466 of 1988 (The Long-Term Care Insurance Act of 1988) in prescribing a standard format and the content of an outline of coverage.

- A. The outline of coverage shall be a free-standing document, using no smaller than 10 point type.
- B. The outline of coverage shall contain no material of an advertising nature.
- C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.
- D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage:

[COMPANY NAME]
[ADDRESS--CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[POLICY NUMBER]

- (1) This policy is [an individual policy of insurance].
- (2) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY CAREFULLY!
- (3) TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.
- (a) [Provide a brief description of the right to return--"free look" provision of the policy.]
- (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy. If the policy contains such provisions, include a description of them.]
- (4) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
- (a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.
- (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.
- (5) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [co-insurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

- (6) BENEFITS PROVIDED BY THIS POLICY.
- (a) Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.
- (b) Institutional benefits, by skill level.
- (c) Non-institutional benefits, by skill level.

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits,

this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

(7) LIMITATIONS AND EXCLUSIONS.

Describe:

- (a) Pre-existing conditions.
- (b) Non-eligible facilities/provider.
- (c) Non-eligible levels of care (e.g., unlicensed providers, etc.)
- (d) Exclusions/Exceptions.
- (e) Limitations.

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

- (8) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:
- (a) That the benefit level will not increase over time.
- (b) Any automatic benefit adjustment provisions.
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]
- (9) TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.
- [(a) Describe the policy renewability provisions.
- (b) Describe waiver of premium provisions or state that there are not such provisions.
- (c) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]
- (10) PREMIUM.
- [(a) State the total annual premium for the policy.
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]
- (11) ADDITIONAL FEATURES.
- [(a) Indicate if medical underwriting is used.
- (b) Describe other important features.]

Section 10. Effective Date.

This regulation is applicable to all long-term care insurance policies delivered or issued for delivery in this State on or after the effective date of this regulation which shall be one hundred eighty (180) days after final publication in the State Register.